NOVA Cardiovascular Care

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Acknowledgement of Receipt of Privacy Practices

I, _____, have received a copy of the "Notice of Privacy Practices" for NOVA Cardiovascular Care, Inc. As provided in the notice, terms of the notice may change. If we change our privacy practices, you may receive a revised copy. This notice is available in our office for review. I understand that I may access my medical records at any time and that I may copy or inspect my PHI to be used or disclosed in accordance with NOVA Cardiovascular Care, Inc.'s policy. ____ I understand that NOVA Cardiovascular Care, Inc. may charge me for copies of my medical records or completion of medical forms (including FMLA, Worker's Comp, etc.) and that a fee schedule will be provided to me. Electronic copies of my records can be emailed to me directly or faxed to other providers for free. ____ I understand that a request for a copy of my records must be submitted to NOVA Cardiovascular care in writing and may take up to **7 business days** to process. ____ I understand that NOVA Cardiovascular Care, Inc. has the right to deny me access to my records in certain circumstances that are in accordance with the law; however, in such an instance I will be provided with a denial in writing. ____

Authorization For Use & Disclosure of Personal Health Information

Our Notice of Privacy Practices provides information about we may use and disclose protected health information (PHI) about you. It has been explained to the patient that disclosures may be made to family and friends related to the patient's health with permission provided by the patient. It has also been explained that we will only disclose information relevant to current treatment. Our patient has agreed to only disclose PHI to the following:

Spouse: _____ In Person ___ By Phone___

Parent(s): _____ In Person ___ By Phone ___

Sibling(s): _____ In Person ___ By Phone ___

Other: _____ In Person ___ By Phone ___

Expiration date of authorization: __/___/20___ **OR** Until otherwise specified ____

I, _____, authorize the use or disclosure of my PHI as specified in the Notice of Privacy Practices for NOVA Cardiovascular Care, Inc. I understand the purpose of the authorized use and disclosure of PHI is for use within NOVA Cardiovascular Care, Inc. or for authorized disclosure to another entity subject to the privacy rules of NOVA Cardiovascular Care, Inc. for treatment, payment, or healthcare operation purposes. I also understand that is the organization authorized to receive my PHI is not a health place or health care providers, that organization may disclose my PHI and it may no longer be protected under federal privacy rules and regulations. I understand that this authorization is voluntary and may be revoked at any time. I understand that I may ask questions of NOVA Cardiovascular Care, Inc. if I do not understand any information contained in the Notice of Privacy Practices.

Printed Name: _____ Date: ___/___/_____

Signature: _____ Relationship: _____